STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E531	A. BUILDING _____ B. WING _____	C 01/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEARNY COUNTY HOSPITAL LTCU	607 COURT PL LAKIN, KS 67860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaint #KS00062095.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to update/revise 1 of 3 sampled residents nursing care plans after the resident experienced falls. (#103)	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 280	Continued From page 1 Findings included: - Resident #103's 12/11/12 significant change MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 3 which indicated severe cognitive impairment. The resident required extensive assistance of 1 person for transfers, walking in room and corridor, toilet use and used a walker and wheelchair for mobility. The assessment indicated the resident had 1 non-injury fall since the prior assessment. Resident #103's 12/24/12 CAA (care area assessment) summary related to cognition indicated the resident's safety awareness had improved with stable mood and few hallucinations and delusions. Resident #103's 11/6/12 nursing care plan stated, "I am at risk for falls due to decreased mobility and poor safety awareness." The care plan also included fall prevention strategies of chair/bed alarms, use of a gait belt, and safety checks every 2 hours. The care plan included revisions after a fall on 11/5/12, but lacked any revisions after the resident had falls on 10/11/12 and 11/11/12. Progress notes for resident #103 revealed the resident had non-injury falls on 10/11/12 and 11/11/12. The facility's August 2011 Fall Prevention policy stated, "the nurse will individualize the resident's care plan...based on the fall assessment and interventions chosen to prevent a fall from	F 280		

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F 280	Continued From page 2 occurring....Update the care plan in Optimus [computer program electronic records] to reflect new interventions based on the fall." During an observation on 1/3/13 at 11:54 a.m., direct care staff E assisted resident #103 from his/her room to the dining room using a gait belt and walker. During an interview on 1/3/13 at 4:44 p.m. administrative nurse A confirmed resident #103's nursing care plan lacked revisions following the falls on 10/11/12 and 11/11/12. He/she stated the nurse should update the care plan to prevent future falls. The facility failed to update/revise resident #103's nursing care plan in order to prevent future falls after the resident experienced falls on 10/11/12 and 11/11/12.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents with 3 sampled for review. Based on observation, interview, and record	F 323		

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F 323	Continued From page 3	F 323		

review, the facility failed to ensure 1 of 3 sampled residents received adequate supervision and assistive devices to prevent accidents when facility staff failed to use a gait belt during a transfer. (#101)

Findings included:

- Resident #101's 10/25/12 quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 8 which indicated moderately impaired cognition. The resident required extensive assistance of 1 person for transfers, walking in his/her room and corridor, toilet use, and used a walker for mobility.

Resident #101's 1/27/12 CAA (care area assessment) summary related to falls stated, "Resident is at risk R/T [related to] previous history of falls, history of hip fracture, decreased mobility and strength....Staff to assist with [his/her] ADL [activities of daily living] needs, transfers, and ambulating....Assistive devices used gait belt and wheelchair."

Resident #101's 11/2/12 nursing care plan for falls stated, "I am at risk for falls due to weakness and decreased physical mobility. I require staff assistance of one for transfers/ambulation....".

The "CNA [certified nurses aide] Daily Report Sheet" provided to direct care staff included the following directions for resident #101: "Walker, scooter, gait belt, 1 assist, extensive ADL assist...".

Resident #101's 12/20/12 fall risk assessment

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F 323	Continued From page 4	F 323		

revealed a score of 22 which identified the resident as "at risk" for falls.

The June 2011 facility policy titled "Gait Belts" stated, "To assure safety of our patients/residents a gait belt must be worn when transferring or ambulating a patient/resident unless contraindicated".

During an observation on 1/3/13 at 1:29 p.m. resident #101 stood and held on to a walker without the use of a gait belt while direct care staff D changed an incontinence pad. A gait belt hung on the walker, not in use. The resident then slowly turned and sat in his/her recliner.

During an interview on 1/3/13 at 1:35 p.m. direct care staff D stated he/she only used the gait belt with resident #101 if he/she seemed unsteady.

On 1/3/13 at 4:55 p.m. administrative nurse A confirmed staff should use a gait belt for resident #101 for transfers/ambulation.

The facility failed to ensure resident #101 received adequate supervision and assistive devices (gait belt) to prevent accidents.